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ABSTRACT

This paper describes the implementation of an inpatient treatment program for Vietnam combat veterans exhibiting symptoms related to Post-Traumatic Stress Disorder, at the North Chicago Veterans Administration Medical Center. Issues related to organizational and staff problems encountered during the program are outlined, and unique problems associated with Vietnam combat veterans are discussed. Impediments to the program in several areas are described, including: (1) people problems (attitudes, opinions and biases); (2) diagnostic certainty; (3) perceptions of caregivers; (4) patient behavior; (5) policy decisions involving the Veterans Administration; (6) resources; and (7) staff assignments. The importance of dealing with the smallest details of a program is stressed, since these problems can quickly become a big issue and can form a convenient focus away from treatment. (JAC)

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INPATIENT TREATMENT OF VIETNAM VETERANS WITH POST-TRAUMATIC STRESS DISORDER: TREATMENT ISSUES AND STRATEGIES

IMPEDIMENTS IN INSTITUTIONAL IMPLEMENTATION

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INPATIENT TREATMENT OF VIETNAM VETERANS WITH POST-TRAUMATIC STRESS DISORDER: TREATMENT ISSUES AND STRATEGIES

IMPEDIMENTS IN INSTITUTIONAL IMPLEMENTATION

I. INTRODUCTION:

The North Chicago Veterans Administration Medical Center began planning for the establishment of an inpatient treatment program for Vietnam combat veterans exhibiting symptoms related to Post-Traumatic Stress Disorder (PTSD) in the fall of 1981. Numerous meetings and discussions were held regarding program design, treatments, interventions, staffing and resources culminating in a program proposal for the Stress Disorder Treatment Unit (SDTU). This proposal was subsequently reviewed by the Center's Mental Health and Behavioral Sciences Council and approved by management for implementation beginning April 1982. Since that time, the SDTU has screened over 500 combat veterans for admission and treated over 250. The following outlines several issues related to organizational and/or people problems that were encountered during the course of the past 2½ years. Many of these issues are, or should be, readily apparent to health care providers. Interestingly enough, many of the issues were addressed (or so we thought) in our planning for the SDTU and in the training we provided staff prior to admitting patients to our program. Yet the road to implementation has been a rocky one, with significant ups and downs.

While it is easy to retrospectively criticize the behavior of others, that is not the intent of this paper. It is hoped that by exploring these issues, others may avoid similar problems should they choose the same path. While several of the issues discussed are inherant to the implementation process for all new health care programs within an institution, an attempt is made to identify the unique problems associated with Vietnam Combat Veterans.

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II. IMPEDIMENTS:

a. People - perhaps it is too obvious to be considered, but nonetheless, people represent a very serious impediment to program implementation at all levels. People hold attitudes, values, beliefs, opinions and biases. Our training as psychologists leads us to understand these issues within individuals, but they are too often misunderstood or ignored during program implementation. Throughout the areas discussed below, people problems will continue to surface. People who work in institutions are typically resistant to change (or should we say people in general), are protective of their turf and perogatives, are subject to changes in mood, affect and motivation. The solution to such people problems is never simple, however, the reformulation of the problems as an interactive or social issue and the use of psychological intervention skills with the institution (and its people) viewed as the "client" is certainly worth consideration.

b. Diagnostic Certainty - A serious problem developed early in our program development regarding the diagnosis of PTSD. The primary problem was a serious belief on the part of most of our psychiatrists that PTSD did not exist. The resulting struggle to ensure adequacy of diagnostically relevant data seemed to only increase the perception that PTSD is merely a figment of the imagination of a group of malcontents. The "professional" differences of opinions transcended the behavioral based DSM III and resulted in both sides taking a careful look at our own biases as they relate to PTSD as a diagnostic category. The problem was exacerbated by the fact that this diagnostic category represented both a new category of psychiatric "disorder" and was unique, in that veterans came to us seeking, and in some cases, demanding to be given a psychiatric label. Such behavior was immediately seen as suspect and representing an attempt to dupe the government into providing compensation. This coupled with our own inexperience in making the diagnosis and the perceived fakeability of symptoms

posed serious conflict between psychiatrists and psychologists. While there is no simple solution for these issues, acceptance of the fact that multiple, concurrent psychiatric diagnosis can and do exist is a beginning. A position of compromise somewhere between "I don't believe it exists" and "Yup, he's got it and only it" is necessary.

c. Perceptions of Care Givers: While professionals generally limited their discussions to the philosophical and "rational" arguments involved in full and accurate diagnosis, non-professionals expressed their perceptions much differently. Many staff expressed fear of potentially violent behavior by these veterans even though the probability was not really different from more familiar psychiatric patients. This was not a surprising attitude given the media image of the A-Team, Magnum PI, newspapers, etc. Interestingly enough, many Vietnam veterans employed in the facility held a negative impression that was voiced most eloquently by a security officer as "They're just a bunch of cry babies." A position further explained by "I was there and I don't have any problems." This represented a unique response by a person known for his care and compassion for veterans of other eras. These attitudes were not unique to particular groups and were pervasive throughout the medical center. The establishment of a "special" program for this veteran group appeared to creat a universal negative response from throughout the staff in the medical center. Rumors ran rampant and were embellished at an unprecedented level.

d. Patient Behavior: Most everyone accepts the general notion that the Vietnam Veteran is a product of the "Me generation" a factor that has historically contributed to perceptions of staff as discussed above. For many staff, their first contact with Vietnam Veterans occurred in the late 60's and early 70's when these veterans made their first appearance and demands of the VA as a system. They were not compliant, demanded attention now and like the proverbial bureaucratic elephant, 10 years later this behavior had not been forgotten.

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Add to this a different mode of dress, a willingness to challenge staff decisions, a questioning attitude about established rules, regulations, etc., posed a serious "threat" to historical organizational patterns of practice. The problems of patient behavior and attitude, however, went beyond just the historical remberances of staff. A very clear attitude (and associated behavior) on the part of these veterans that the VA as an institution of government was bad, vile, terrible, incompetent and worse, is pervasive. The dilemma of hating the VA and yet needing the VA (for treatment or at least for compensation) was a significant double bind both at the individual interpsychic level and at the peer group inspired, behavioral level. Our program began with outreach groups, held off the medical center grounds, to begin to break down the attitudes of the veterans regarding the VA and to reinforce the concept that the VA is really caring people. That they encountered differing attitudes as discussed above was not expected and as much a shock to us as it was a confirmation of the veterans expectations.

Yet another factor of significant proportions was the clear fact that a majority of veterans admitted to our program used or abused drugs and/or alcohol. Rumors ran rampant that such use was both known and condoned, and that it occurred with regularity on the unit. While numerous methods were employed to counteract such behavior (which are to be discussed by another speaker) suffice it to say that such behavior on the part of patients will result in no gain from psychotherapy, significant internal friction and the ultimate demise of a program.

Our solution has been simple and straight forward: No use of alcohol or drugs while on the program and routine urinalysis on a weekly basis, no exceptions. Violations result in administrative discharge. Applicants for admission with serious pre-existing problems with substance abuse are referred for appropriate treatment <u>prior</u> to beginning the SDTU.

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e. Policy Decisions: No treatment program can operate apart from the overall structure of the Agency as expressed in its global statements of policy. At the time of our implementing efforts two major policy concepts proved problemmatic (not necessarily bad). The first was the general feeling that the VA Medical Centers had been basically unresponsive to the needs of Vietnam veterans, specifically that traditional psychiatric treatment programs were both inappropriate and ineffectual for the "low grade" psychiatric problem (PTSD) of the Vietnam Vets. Out of this feeling grew the Operation Outreach program with its 130+ storefront, rap groups, oriented Vet Centers. While officially a part of the VA, and even "administratively" tied to VA Medical Centers, the Vet Centers became the focal point for many Vietnam veterans seeking assistance from the VA. Originally conceived of as a readjustment counseling and referral operation it unfortunately tended to reinforce the notion that VA Medical Centers weren't good resources from which to seek help. Our program implementation strategy required involvement of staff's from area Vet Center's that now constitute our most important referral source. At the time of our program implementation, it was a common management feeling that the Vet Centers were sufficient and that inpatient treatment unnecessary despite the Vet Centers staff's feelings to the contrary. Fortunately, this "policy" is changing with legislation to support more inpatient programs.

The second major issue revolved around VA policy on compensation and in particular the difference between service connected and non-service connected compensable disorders. There is not sufficient space or time to herein address the many problems inherant in this policy. The very structure of the Agency, having the Departments of Medicine and Surgery (DM&S) and Veteran Benefits (DVB) posed significant problems, particularly for veterans who were motivated to obtain confirmation of distress by being awarded compensation for

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PTSD. Our program's strict adherence to its role as assessors and treators (DM&S) and avoidance of the role of adjudicators and compensators (DVB) has been important and distinctive. In point of fact the unit was designated the SDTU as opposed to the PTSD unit to disavow veterans of the notion that being in the program meant you had IT (PTSD)!

f. Resources: Any program plan addresses the resources necessary for successful implementation. It is usually the most eloquent of any program proposal and includes as much data and statement of fact as may be reasonable to gain its acceptance. The reality of our Agency is that the "Days of More" are gone. With resources dwindling, and DRG's coming on strong, the reality of resources for new programs is that some program must be discontinued in order for a new program to start. At the time we began our program, we were experiencing vacancies in our inpatient psychiatry beds. Our plan was to operate a 40 bed unit within existing resources. A key phrase, a management philosophy, this statement "within existing resources." Unspoken is the concept "prove what you can do with what you have and we'll consider giving you more." Reality based, certainly; doable, hardly. We successfully burned several staff, created havoc for ourselves, generated discontent and unfulfilled expectations on the part of our veteran clients and almost a law suit. Our program design and its stated goals couldn't be done within existing resources. The people and psychotherapy intensive nature of our program required more people and fewer patients, a level we have finally achieved. Beware the concept "within existing resources" lest you are caught, as we were, by the very nature of your zeal to do good things and ending up in a position of being unable to do anything. Reality constraints make it wise to not do something you know must be done if the best possible outcome is a half done job.

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g. People: Not people in general, not other hospital personnel, but the few chosen people who will work on your unit. Our staff were initially all volunteers (no supervisor wanted to assign anyone to work on the SDTU) who were given one month of intensive training prior to the unit seeing its first patient. In retrospect a nice idea but not very effective. Our most significant problem developed around the concept of "Who can help me?" expressed by the veterans. Nursing assistants were seen as people to be disregarded, only psychologists could help. One psychologist for 30-40 of these patients is impossible. Nursing staff were unhappy with their role and rejection by the vets, social workers were not much better and we won't even discuss the attitudes toward the psychiatrist. A very flattering situation, but both unrealistic and untenable. The result included nursing desiring to have nothing to do with these "bad" patients who had no respect for their capabilities, and a proposal (by nursing) to give up nine of their 21 positions for rehab counselors to support the program 24 hours, seven days per week. In addition, part-time coverage by a physician was proposed, via the mental health clinic (a half mile away).

The Message: Caring and concerned people are important, but a recognition of the significant change in roles is absolute. Flexibility on the part of not only the staff assigned but their supervisors is essential. This veteran population did not need ADL's, they could shower and shave and wanted to. They knew the date, time, place, past two presidents, etc., yet our nursing assistants were being asked to do their job as they were trained with severely involved psychiatric patients and to run these groups. Today, a much better climate exists, nursing staff are a vital and integral part of the program. They run groups appropriate to the needs of these veterans and are flexible in their implementation of the policies of Nursing Service.

Another people issue is worthy of discussion. We made a policy decision before opening the program that precluded oriental staff at any level. This was

done as much out of our concern for the staff members safety as it was to ensure acceptance of the program by the veterans. That these veterans must learn to deal effectively with orientals is a fact of life in our medical center; our judgement was that it would prove too problemmatic during the first stages of treatment. We have, however, reassessed our position, and with the assistance and permission of the veteran patients have begun a supervised experience for a Vietnamese, female resident in Psychiatry.

The issue has often been raised regarding the necessity of having combat veterans as members of the staff. While choosing not to debate this complex issue here, it is clear in our experience that staff who are combat veterans can be very helpful, especially in evaluating the accuracy of information provided during our screening process. In my judgment however, prior combat experience on the part of the staff is neither sufficient or necessary for successful treatment. The usual attributes of caring, concern, compassion and competence must be present for anyone to be effective in developing the trust necessary for successful interventions.

h. People: Notpeople in general, or hospital workers in general or treatment staff assigned to the job. These people are the management team of the medical center. Once again, the clinical skills of psychologists should be enlisted in understanding the needs and motivations of the management team. Too often assumptions are made regarding management's desire to provide the highest quality, innovative, treatment programs regardless of reality. Assessment of such factors as risk taking orientation, timing, credibility of the proposors (not the proposal), resource picture of the medical center, outside pressure including veteran groups, VACO and politics, all figure into a complex picture that can make or break any proposal. Add to this the "good ol' boy" telephone network across the VA, of top management with its

stories, rumors and rivalry of successes and dismal failures, the "friendly" competition between similar medical center settings within a district or region and the complexity grows.

Many times we as treatment providers and psychologists seem to forget, or choose to ignore, the concept of payoff and reinforcement that motivates people in general. Managers operate within the same system. In our instance, our program was begun despite the general perception that top management was not oriented to risk taking. In my assessment, credibility of the proposers and the implied assurances of being able to take care of any problems that might arise were significant factors in starting the program. No promises were made, in fact, several sessions were spent describing the possible problems that might arise and the ways in which they might be handled were outlined. Despite a great deal of skepticism about its success, we proceeded.

3. Summary

No one person or group of people can possible anticipate every possible factor involved in the implementation of a new treatment program. This is especially true when the program involves multiple factors that either can't be predicted or controlled. In fact, most programs experience significant "growing pains" mostly related to unexpected or overlooked problems. In my judgment, such unknowns are part of the challenge and excitement of trying something new.

In concluding this very sketchy review based on our experience, I would offer one suggestion for those who would undertake such a program. Pay attention to details, the small d's of this rather large projective endeavor. A look at the whole picture is necessary and appropriate for formulation of your concepts and philosophy but small details can kill a program. Your management team, the treatment staff and yes, even the clients you serve, will appreciate your efforts. In our experience, even the smallest of details unattended can quickly become both a big issue and a convenient focus away from treatment.